S.C. SECOND INJURY FUND REIMBURSEMENT REQUEST FORM

Mail To:
S.C. Second Injury Fund
220 Executive Center Drive
Winthrop Building, Suite 119
Columbia, S.C. 29210

Second Injury Fund No.
Carrier No.
Date of Accident
Compensation Rate

PLEASE REVIEW INSTRUCTIONS ON REVERSE SIDE

Employee:	Employer:	Carrier

Date of first payment of compensation:

Date for 100% Medical Reimbursement:
(1st Day of 79th Week after accident)

Type of Comp Paid	Date Beginning	Date To	Weeks	Amount
TEMPORARY TOTAL				
TEMPORARY PARTIAL				
PERMANENT PARTIAL				
PERMANENT TOTAL				
DEATH OR OTHER (*SPECIFY*)				
		TOTAL INDEMNITY TO DATE		
LESS 78 WEEKS	**WEEKS** / **AMOUNT** Wks at Full Compensation Rate Wks at Temporary Partial Rate			
		NET REIMBURSABLE INDEMNITY REIMBURSEMENT		
LESS ANY PRIOR INDEMNITY REIMBURSEMENT				
TOTAL INDEMNITY REIMBURSEMENT REQUESTED				
TOTAL MEDICAL REIMBURSEMENT REQUESTED *(ENCLOSED ITEMIZED LIST - SEE INSTRUCTIONS)*				
TOTAL REIMBURSEMENT REQUESTED				

I hereby certify, that to the best of my knowledge and belief, the information as indicated above is true and correct as of this date: _____

MAIL REIMBURSEMENT TO:

_____
NAME

_____
ADDRESS

_____

_____
NAME OF CARRIER OR EMPLOYER, IF SELF-INSURED

SIGNED BY _____

TITLE _____ DATE _____